



Substance Use Disorder and Problem Gambling Treatment

Data Integrity Reports Manual

June 2020

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INTRODUCTION

The Substance Use Disorder (SUD) treatment and Problem Gambling Treatment programs have developed a series of **Monthly**, **Quarterly**, and **Informational** Reports to assist in program management and monitoring of Substance Use Disorder and Problem Gambling treatment data.

Monthly/Quarterly Reports are generated by the Sequel Server Reporting System (SSRS) via subscription on the 17th of each month and sent to the generic “data integrity” email address that is on file with IDPH for each program. These reports identify submitted treatment data/activities with identified concern(s). These reports may be run more frequently as requested by contacting the Help Desk at sapgdata@idph.iowa.gov. **Informational Reports** are resources to assist with program management of treatment services.

All data integrity issues should be corrected by the 15th of the month following receipt of the data integrity report(s). For providers using I-SMART, corrections made in ISMART will be updated in the CDR the following Monday. For providers submitting directly to the Central Data Repository, submit corrections with your next file submissions.

Discharge Policy Update: To support appropriate patient engagement in ongoing treatment services that support recovery, IDPH suspends the 60-day administrative discharge requirement. When treatment services have not been provided to a patient for 60+ days, licensed programs have the option to complete and report a discharge, or keep the case open to monitor patient recovery process until such time as the patient chooses to discontinue monitoring/services. For additional information on continued service and transfer/discharge criteria, please refer to The ASAM Criteria – Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions, Third Edition. For licensure requirements on management of care review timeframes, please refer to Iowa Administrative Code 641—155.21.19. Decisions concerning continued service, transfer, or discharge involve review of the treatment plan and assessment of the patient’s progress, requiring the same type of multidimensional assessment process that led to admission to treatment.

For IPN Providers: Treatment data that are corrected/updated/added will be reflected on the IPN Claim Summary and IPN Claim Detail reports for the following month’s claim submission.

MONTHLY REPORTS – SUBSTANCE USE DISORDER TREATMENT

SUD - **ADMISSION RECORD MISSING MATCHING ENCOUNTER** [SUBSCRIPTION]

A separate report will be generated for each EVENT TYPE ACTIVITY (Crisis Intervention, Placement Screening, and Admission) containing the UCN’s of patients who have a completed EVENT TYPE record (Crisis, Placement Screening, Admission) that does not have a matching SERVICE/ENCOUNTER and a matching EVENT TYPE (Crisis, Placement Screening, Admission).

ACTION:

- If the report shows “0” records, then no corrections are necessary.
- For providers using I-SMART, verify that the listed ASSESSMENT ACTIVITY took place. If so, then correct the ENCOUNTER for the ACTIVITY to match the ACTIVITY date. If not, create an ENCOUNTER for the ACTIVITY date.
- For providers submitting directly to the Central Data Repository, update the patient record as appropriate in your clinical system and resubmit with your next file submissions.

SUD - ADMISSION LIST WITH No ENCOUNTERS IN LAST 60 DAYS AND No DISCHARGES [SUBSCRIPTION]

This report contains a listing of patients who have a completed ADMISSION record and do not have a SERVICE/ENCOUNTER submitted/entered for 60 days from the last service date AND do not have a DISCHARGE module/record completed/submitted.

ACTION:

- If the report shows “0” records, then no corrections are necessary.
- For providers using I-SMART, verify the discharge status, and if the DISCHARGE ASSESSMENT has not been completed, complete the DISCHARGE ASSESSMENT. In the case where a listed patient is still active, enter any missing encounters or document in the patient file/record why the case has remained open for 60 days without a documented service.
- For providers submitting directly to the Central Data Repository, update the patient record as appropriate in your clinical system and resubmit with your next file submission.

NOTE: Per the [I-SMART Data Entry Guide - Update \(June 2019\)](#) IDPH has suspended the 60-day administrative discharge requirement. When treatment services have not been provided to a patient for 60+ days, licensed programs have the option to complete and report a discharge, or keep the case open to monitor patient recovery process until such time as the patient chooses to discontinue monitoring/services.

SUD - VALIDATION REPORTS

This group of reports identifies providers with submitted patient records that have a missing, incomplete, or an incorrect value. Providers will receive an email from sapgdata@idph.iowa.gov containing a spreadsheet for each of the following where an ERROR CODE is listed that identifies the validation concern.

- **Client.xxx.bad.xlsx (Client Profile Report):** This is a patient with a CLIENT PROFILE record that has a field(s) within the record that is missing data or contains an invalid value. There is also a **Delete_Client.xxx.bad.xlsx** file that indicates a delete record submitted that is missing data or contains invalid data.
- **Admission.xxx.bad.xlsx (Admission Report):** This is a patient with an ADMISSION record that has a field(s) within the record that is missing data or contains an invalid value. There is also a **Delete_Admission.xxx.bad.xlsx** file that indicates a delete record submitted that is missing data or contains invalid data.
- **Service.xxx.bad.xlsx (Service Report):** This is a patient with a SERVICE/ENCOUNTER record that has a field(s) within the record that is missing data or contains an invalid value. There is also a **Delete_Service.xxx.bad.xlsx** file that indicates a delete record submitted that is missing data or contains invalid data.
- **Discharge.xxx.bad.xlsx (Discharge Report):** This is a patient with a DISCHARGE record that has a field(s) within the record that is missing data or contains an invalid value. There is also a **Delete_Discharge.xxx.bad.xlsx** file that indicates a delete record submitted that is missing data or contains invalid data.
- **TEDS Error Summary Report (Excel file)**
 - **Admission Tab:** This is a patient with a TEDS ADMISSION record that has a field(s) within the record that is missing data or contains an invalid value.
 - **Discharge Tab:** This is a patient with a TEDS DISCHARGE record that has a field(s) within the record that is missing data or contains an invalid value.

ACTION:

- For providers using I-SMART, verify the patient's UCN in I-SMART and update/correct the field(s) with an error.
- For providers submitting patient data to the Central Data Repository, correct the identified field with the error in your clinical system and resubmit with your next file submission.

SUD - DATA INTEGRITY - ADMISSION ENVIRONMENT VALIDATION CHECK [SUBSCRIPTION]

This report contains a listing of patients who have a completed ADMISSION record with an Actual Environment value of “No Treatment Recommended.”

ACTION:

- For providers using I-SMART, verify the patient UCN in I-SMART and update the Actual Environment (Level of Care) to the Actual Environment that the patient was admitted to. If the patient was not admitted to treatment, delete the Admission record (which may include deleting any linked encounters/services).
- For providers submitting patient data to the Central Data Repository, correct the identified field with the error in your clinical system and resubmit with your next file submission. If the patient was not admitted to treatment, send a delete record for the impacted Admission. Please note this may mean sending a delete record for any linked services.

SUD - POSSIBLE DATA ENTRY ERRORS - PREGNANT STATUS [SUBSCRIPTION]

This report contains a listing of patients reported as “male” with a PREGNANCY STATUS as “YES”.

ACTION:

- For providers using I-SMART, verify the patient's UCN in I-SMART and update/correct the field(s) with an error.
- For providers submitting patient data to the Central Data Repository, correct the identified field with the error in your clinical system and resubmit with your next file submission.

SUD - DATA ENTRY ERRORS - IV DRUG STATUS [SUBSCRIPTION]

This report contains a listing of patient records where the IV Drug Use status on the Crisis/Placement Screening/Admission record does not align with the Substance Method and frequency reported or vice versa. Note: In I-SMART there is also a Past IV Drug Use field on the Client Intake; this field on the Client Intake is NOT referenced in this report.

ACTION:

- For providers using I-SMART, verify the patient's UCN in I-SMART and update/correct the Crisis/Placement Screening/Admission field(s) with an error.
 - IV Drug User (column D) and no method as IV Injection (columns I, L, O), **OR**
 - Not an IV Drug User and IV Injection as a method.
- For providers submitting patient data to the Central Data Repository, correct the identified field with the error in your clinical system and resubmit with your next file submission.
 - IV Drug User (column D) and no method as IV Injection (columns I, L, O), **OR**
 - Not an IV Drug User and IV Injection as a method.

SUD - MISSING ADMISSION RECORDS - CENTRAL DATA REPOSITORY [SUBSCRIPTION]

This report contains a listing of patients who have a completed ENCOUNTER record (Crisis Intervention/Placement Screening/Admission) and there is not a corresponding ADMISSION RECORD (Crisis Intervention/Placement Screening/Admission).

ACTION:

- For providers using I-SMART, verify the patient UCN in I-SMART and complete the missing ADMISSION RECORD (as applicable) for the ENCOUNTER Service Date listed.
- For providers submitting directly to the Central Data Repository, complete the missing ADMISSION RECORD (as applicable) for the ENCOUNTER Service Date listed.

This report contains a listing of patients who have a completed ENCOUNTER, ADMISSION, and/or DISCHARGE record and there is not a corresponding PATIENT RECORD completed/submitted.

ACTION:

- For providers using I-SMART, verify the Patient UCN in I-SMART and complete the missing CLIENT PROFILE.
- For providers submitting directly to the Central Data Repository, complete the missing CLIENT PROFILE information and resubmit the patient record.

SUD - **ADMISSION RECORDS - POSSIBLE DATA ENTRY ERRORS (DETAIL)** [SUBSCRIPTION]

SUD - **ENCOUNTER RECORDS - POSSIBLE DATA ENTRY ERRORS (DETAIL)** [SUBSCRIPTION]

SUD - **DISCHARGE RECORDS - POSSIBLE DATA ENTRY ERRORS (DETAIL)** [SUBSCRIPTION]

These reports contain a listing of patients who have a completed record in the Admission table (Crisis, Placement Screening, Admission), Encounter table, or Discharge table in the CDR, in which the date of the activity took place after the “Created” date of the activity.

ACTION:

- Each report contains a listing of patients where the day differential between the activity date/start date and create date is less than <0 or >89 days, or was before 7/1/2009.
- Providers are to investigate the identified record and as appropriate correct the activity date as follows:
 - For providers using I-SMART, enter the correct activity/start date.
 - For providers submitting patient data to the Central Data Repository, correct the start date in your system and resubmit the corrected record.

SUD - **ADMISSION DATA LAG REPORT** [SUBSCRIPTION]

SUD - **ENCOUNTER DATA LAG REPORT** [SUBSCRIPTION]

SUD - **DISCHARGE DATA LAGE REPORT** [SUBSCRIPTION]

The Data Lag Reports are an additional resource to assist with program management of treatment services. These reports are sent via subscription. Each provider data lag report lists by facility the unduplicated patient count (number of patients served) for each facility. Included is the average, minimum and maximum “Data Lag” (the difference between the date the record was CREATED in the source system and the ACTIVITY DATE/START DATE of the record).

ACTION:

These reports are informational to assist providers in monitoring data entry lag as a data integrity and Quality Assurance activity. No specific action is required.

UNFINISHED CLIENT ACTIVITIES

The Unfinished Client Activity Report is an additional resource to assist with program management of treatment services. This is a report that lists unfinished patient activities. The Unfinished Client Activities report is located in I-SMART/Reports/QA-QC/Unfinished Client Activities.

It is recommended that the report is run each month to assist in identifying patients with incomplete activities in the Problem Gambling and/or Substance Use Disorder Domains.

Under “**Choose Activity(s)**” select:

For Gambling:

- Client Information (Profile)
- Gambler Screening
- Gambling Assessment

For SUD:

- Admission
- Client Information (Profile)
- Crisis Intervention
- Discharge
- Placement Screening

NOTE: Any incomplete records listed in these reports are not submitted to the CDR.

Click on “**On Screen**” or “**Export**” to view the results.

Facility	Incomplete Activity	Date Created	Case	Client	Date of Birth
Test 2	Admission	7/2/2008	1	Katulu, Calluf	6/6/1966
Test Facility	Placement Screening	11/13/2008	1	test, Tap	6/5/1975
Test Facility	Admission	12/4/2008	1	Stryhee, Jennifer	1/1/1960
Test Facility	Placement Screening	2/18/2011	2	Client, Admit	12/23/1954
Test Facility	Client Information (Profile)	12/5/2008	1	Test, Copresent	9/7/1965
Test Facility	Client Information (Profile)	2/17/2010	1	LaRue, Kyle	2/2/1952
Test Facility	Client Information (Profile)	3/8/2010	1	Morris, Mary	10/9/1986
Test Facility	Client Information (Profile)	8/11/2010	1	Jones, Steve	3/15/1960
Test Facility	Client Information (Profile)	10/22/2010	1	Test, Test	1/1/1966

NOTE: For the Client Profile, the report will return all unfinished activities for both Substance Use Disorder Treatment and Problem Gambling Treatment.

ACTION: After completing the On Screen or Export process:

- Return to the I-SMART Home Page.
- From the Client List, search for each patient listed in the report.
- Review the patient’s Client Activity List to determine what information needs to be entered to complete the activity.

GAMBLING ASSESSMENT RECORD MISSING MATCHING ENCOUNTER *[SUBSCRIPTION]*

There will be a separate report for each ASSESSMENT TYPE (Crisis Intervention, Placement Screening, and Admission) containing the UCN's of patients who have a completed GAMBLING ASSESSMENT (Crisis, Placement Screening, Admission) that does not have a matching SERVICE/ENCOUNTER entered in I-SMART that has a matching EVENT TYPE (Crisis, Placement Screening, Admission).

ACTION:

- If the report shows "0" records, then no corrections are necessary.
- For the listed UCN's on the report, verify that the listed ASSESSMENT ACTIVITY took place. If so, then correct the ENCOUNTER for the ASSESSMENT ACTIVITY to match the ASSESSMENT ACTIVITY date. If not, create an ENCOUNTER for the ASSESSMENT ACTIVITY date.

GAMBLING ADMISSION LIST WITH NO ENCOUNTERS IN LAST 75 DAYS AND NO DISCHARGES *[SUBSCRIPTION]*

This report contains a listing of patients who have a completed ADMISSION record and do not have a SERVICE/ENCOUNTER submitted/entered for 75 days from the last service date AND do not have a DISCHARGE module/record completed/submitted.

ACTION:

- If the report shows "0" records, then no corrections are necessary.
- For the listed UCN's on the report, verify the discharge status, and if the DISCHARGE ASSESSMENT has not been completed, complete the DISCHARGE ASSESSMENT. In the case where a listed patient is still active, enter any missing encounters or document in the patient file/record why the case has remained open for 75 days without a documented service.

NOTE: IDPH has suspended the 60-day administrative discharge requirement. When treatment services have not been provided to a patient for 75+ days, licensed programs have the option to complete and report a discharge, or keep the case open to monitor patient recovery process until such time as the patient chooses to discontinue monitoring/services.

Problem Gambling Informational Reports can be generated by each provider as needed to assist with program management of treatment services, and can aid in submission of claims in IowaGrants.gov using I-SMART service/encounter data.

These reports can be found by first logging into I-SMART, clicking on the SSRS icon (upper right hand corner), and then navigating to **Provider Reports Folder>IPN Problem Gambling Treatment Reports** folder.

30 DAY FOLLOW-UP REPORT

This report shows admitted patients by UCN who have not had a 30 Day Follow-up completed.

ACTION:

The report may be used to monitor and ensure for each admitted patient that the 30 Day Follow-up is completed within 45 days of Admission.

IGTP 24 MONTH PATIENT ACTIVITY REPORT (NO DISCHARGE)

This report contains the UCN, Admission Date, and last encounter/service date for those patients who have an Admission date that occurred 24+ months ago.

ACTION:

The report may be used to monitor patients who have been in services for 24+ months.

- If there has not been any activity since the last service date listed, and the patient is not expected to return, then complete the DISCHARGE ASSESSMENT.
- If no service date is listed, enter the missing encounters, and if there has not been any activity in the last 45 days, and the patient is not expected to return, then complete the DISCHARGE ASSESSMENT.

IGTP TREATMENT ENCOUNTER DETAIL

This report contains the encounter detail for problem gambling treatment service encounters for the chosen report period.

ACTION:

The report may be used to assure all encounters have been entered into I-SMART. As of January 1, 2019, encounters do not need to be released to billing for the IowaGrants.gov claim and aid in reconciliation. Please see the *IPN PG Claim Detail* and *IPN PG Claim Summary* reports in the **IPN Problem Gambling Treatment Reports** folder.

IPN PG - OTHER COVERED SERVICES – ALL PATIENTS (PROJECT PERIOD)

This report will list by UCN the OTHER COVERED SERVICES that have been entered into I-SMART for the project period.

ACTION:

The report may be used to monitor/reconcile OTHER COVERED SERVICE activity with OTHER COVERED SERVICE documentation and monitor individual RSS caps and the patient maximum for the project period.

IPN PG - OTHER COVERED SERVICES - PATIENT (PROJECT PERIOD)

This report allows a provider to search by UCN the OTHER COVERED SERVICES that have been entered into I-SMART for the project period.

ACTION:

The report may be used to monitor/reconcile OTHER COVERED SERVICE activity with OTHER COVERED SERVICE documentation and monitor individual OTHER COVERED SERVICE caps and the episode/project period caps.

IPN PG - OTHER COVERED SERVICES - PATIENT (PROJECT PERIOD) ENCOUNTERS

This report will list by UCN the OTHER COVERED SERVICES Encounters that have been entered into I-SMART for the project period.

ACTION:

The report may be used to monitor/reconcile OTHER COVERED SERVICE activity with OTHER COVERED SERVICE documentation and monitor OTHER COVERED SERVICE caps and the episode/project period caps.

PROBLEM GAMBLING DOMAIN TREATMENT PLAN AND 30 DAY FOLLOW-UP STATUS REPORT

This report will list by UCN the currently active cases by facility for each program. This report contains information on when a treatment plan is due to be created and additional information if the Treatment Plan module in I-SMART is being used. It will also note the 30 Day Follow-up status (when due and date completed), and the Case Status.

ACTION:

The report can be used to monitor treatment plan, 30 day follow up, and case status for all open cases in the problem gambling domain.

- Treatment Plan information (if Treatment Plan is being used in I-SMART) – monitor for treatment plan creation and review dates per program policy/procedure.
- 30 Day Follow-up – Schedule or enter 30-Day Follow-up if Completed Date is blank.
- Case Status - If Discharge Date is displayed, then case needs closed by entering a case closed date on the Client Intake screen.